GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

AUDIT OF SUSPECTED INCIDENTS OF FOSTER CHILDREN MALTREATMENT REPORTED TO THE DISTRICT OF COLUMBIA CHILD AND FAMILY SERVICES AGENCY

AUSTIN A. ANDERSEN

INTERIM INSPECTOR GENERAL

OIG No. 03-2-11RL **March 2, 2005**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

March 2, 2005

Brenda Donald Walker
Director
Child and Family Services Agency
400 6th Street, S.W.
Washington, D.C. 20024

Dear Mrs. Walker:

Enclosed is the final report summarizing the results of the Office of the Inspector General's *Audit of Suspected Incidents of Foster Children Maltreatment Reported to the District of Columbia Child and Family Services Agency* (CFSA) (OIG No. 03-2-11RL). We conducted this audit as a part of an overall audit of CFSA's Management of the Foster Care Program.

In order to solicit management's attention to an urgent audit issue, we issued a Management Alert Report (MAR) No. 04-A-14 (Exhibit B) to CFSA on May 10, 2004, recommending that all incidents of abscondence occurring at CFSA foster care providers be reported to the CFSA Hotline (Hotline). We also recommended that the Hotline staff evaluate and investigate, when warranted, all incidents of abscondence reported to the Hotline. CFSA responded positively to the recommendations and the Deputy Mayor for Children, Youth, Families, and Elders requested CFSA to set completion dates for the planned actions.

Our draft report contained six recommendations for necessary action to correct the described deficiencies. We received responses from CFSA on February 14, 2005. CFSA responded positively to all but one of the recommendations and provided us with updated information to reflect the current progress on the issues. We consider actions taken and/or planned by CFSA to be responsive to Recommendations 2 through 6.

CFSA did not provide an adequate response to Recommendation 1, which requires collection and control over the Critical Event Summary/Update forms to be in a central location. In addition, we have amended this report to include an additional recommendation (Recommendation 7) requiring CFSA to report child care providers involved in repeated cases of child fatality or negligent care to the appropriate licensing authority. We have also amended the Background section of the report at the request of CFSA to reflect specific edits for clarity purposes. Accordingly, we ask that CFSA reconsider its position on Recommendation 1 and provide comments on Recommendation 7 within 60 days from the

date of this report. The full text of CFSA's response to the draft report is included at Exhibit F.

We appreciate the cooperation and courtesies extended to our staff during the audit. If you have questions, please contact William J. DiVello, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,

Austin A. Andersen
Interim Inspector General

AAA/ws

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AUDIT OF SUSPECTED INCIDENTS OF FOSTER CHILDREN MALTREATMENT REPORTED TO THE DISTRICT OF COLUMBIA CHILD AND FAMILY SERVICES AGENCY

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EXECUTIVE DIGEST

OVERVIEW

The Office of the Inspector General, District of Columbia, has completed an audit of the policies and procedures used by the District of Columbia Child and Family Services Agency (CFSA) to manage maltreatment incidents reported for children in its custody or care[1]. This audit is the first of two audits that address various functions associated with the CFSA's mission of protecting and promoting the health, safety, and well being of children in the District of Columbia.

The audit report covers reports of maltreatment incidents (abuse, neglect, other health and safety issues, and unusual incidents) for children either in the custody or care of CFSA. The next report will focus on CFSA's intake and placement process. We conducted this audit as a part of an overall audit of CFSA's management of the Foster Care Program.

Perspective

After a period of receivership imposed by the court, The Center for the Study of Social Policy was the court appointed monitor assigned to assess CFSA's performance. The Center for the Study of Social Policy report dated February 9, 2004, found that CFSA made significant progress in many key areas in the court-ordered final implementation plan, while still needing to improve in others. Among numerous achievements, the Center for the Study of Social Policy noted five direct improvements for the safety and well being of the District's foster care children.

For the first time in the history of the Court's oversight of CFSA, average social worker caseloads have been reduced to less than 20 per worker from the average caseload of 34 cases per worker just 1 year ago. In the management of case plans, CFSA achieved 61 percent against a goal to have case plans for 60 percent of foster care cases. This is a 144 percent improvement over CFSA's baseline performance of 25 percent 3 years ago. CFSA also improved on its 50 percent goal for monthly visits by the social worker to children in foster care. CFSA achieved 54 percent, up from 5 percent less than 3 years ago. Further, CFSA has fully implemented District safety and other standards for licensing of group homes and independent living programs serving children and youth. The goal was to license 80 percent of these facilities. CFSA has licensed 100 percent. Finally, CFSA continues to move away from reliance on group care for young children. Against a goal of no more than 65 children under age 12 in congregate care, CFSA had only 47.

[1] Children in the custody of CFSA receive family services and are legal wards of the District of Columbia. A child that receives CFSA's care represents a child receiving child welfare support from CFSA; however, the child may not be a legal ward of the District of Columbia and/or may be in the physical custody of the child's legal guardian. For consistency purposes in this report, we will use the term custody, but it represents interchangeably both custody and care.

EXECUTIVE DIGEST

Although progress has been made in many areas during the past several years, our audit disclosed that improvements are needed at CFSA to effectively manage suspected maltreatment incident reports.

CONCLUSIONS

CFSA needs to improve the management and oversight of suspected child maltreatment or abuse incidents at foster care facilities/homes. Our review showed that CFSA does not do a thorough job of investigating, documenting, and reporting suspected child maltreatment incidents and is not effectively monitoring the conditions under which care is provided at foster care facilities/homes.

- Reports of suspected child maltreatment incidents prepared by CFSA personnel had not been reported to and maintained by CFSA at a central location.

- Foster care providers did not always report suspected maltreatment incidents to CFSA in the required timeframe.

- Official documentation had not been obtained to determine the cause of death for child fatalities or to review and evaluate for quality assurance purposes

- Reports of suspected maltreatment incidents accepted for investigation were not always completed by the required completion date.

- Investigations of suspected maltreatment incidents for children in CFSA's custody, physically located in a jurisdiction other than the District of Columbia, had not been monitored for completion, results, and recommendations.

- Abscondence incidents were not always reported to the CFSA Hotline for evaluation and tracking purposes in FACES.

As a result of CFSA's inability to effectively manage reports of suspected maltreatment incidents, these children are placed at an increased risk of harm. Further, there is no assurance that all suspected child maltreatment incidents are reported in a timely manner, properly documented, and/or investigated by CFSA; and that the most effective health and safety services are being provided to the children involved in such an incident.

SUMMARY OF RECOMMENDATIONS

We addressed seven recommendations to the Interim Director, CFSA, that we believe are necessary to address the concerns described above. Specifically, CFSA should:

EXECUTIVE DIGEST

- require that the collection and control of Critical Event Summary/Update Forms be in a central location for all suspected incidents of child maltreatment reported to CFSA;

- reemphasize to all foster care providers the requirement to report suspected incidents of child maltreatment to CFSA no later than 24 hours after identifying a suspected incident;

- require that official documentation to determine the cause of death be obtained for the fatality of a child in CFSA's custody;

- screen all child care providers to assure they are adhering to child-care standards and taking action to suspend licensures of those facilities involved in repetitive child fatalities or negligent care;

- ensure that reports of suspected maltreatment incidents that are accepted by the CFSA Hotline for investigation be completed within 30 days after the initial contact with the alleged maltreated child; and

- ensure that investigations of suspected incidents of maltreatment of children in CFSA's care who are placed in another jurisdiction and are referred to that jurisdiction for investigation, are actively monitored to obtain results and recommendations for corrective action purposes.

- report child care providers involved in repeated cases of child fatalities or negligent care to the appropriate licensing authority.

MANAGEMENT ACTIONS

In order to solicit management's attention to an urgent audit issue, we issued a Management Alert Report (MAR) No. 04-A-14 (Exhibit B) to CFSA on May 10, 2004, recommending that all incidents of abscondence occurring at CFSA foster care providers be reported to the CFSA Hotline (Hotline). We also recommended that the Hotline staff evaluate and investigate, when warranted, all incidents of abscondence reported to the Hotline. CFSA responded positively to the recommendations and the Deputy Mayor for Children, Youth, Families, and Elders requested CFSA to set completion dates for the planned actions.

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EXECUTIVE DIGEST

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A summary of the potential benefits resulting from the audit is shown at Exhibit A.

INTRODUCTION

BACKGROUND

Historical Background. In 1991, the District and the American Civil Liberties Union reached an agreement to improve the performance of the District's child protective function. Under the LaShawn A. v. Williams, Modified Final Order established by the court in 1993, the District was directed to comply with many requirements. In 1995, lacking sufficient evidence of improvement, the District was ordered to relinquish its authority over the child protective function, and it was placed in receivership. The District Court issued a consent order in 2000, establishing a process by which the receivership could be terminated.

The order provides that, upon termination of the receivership, a probationary period would be imposed during which certain agreed upon performance standards would be met and requirements fulfilled. In June 2001, the court terminated the receivership; the District established CFSA stand-alone, cabinet-level agency; and CFSA began a probationary period which lasted until January 2003. By that time, CFSA had demonstrated sufficient progress in achieving court-ordered agreements on a series of probationary period performance standards.

CFSA Programs. CFSA is responsible for providing a wide range of support and services to children and families who are at risk or have experienced abuse and neglect. The overall mission of CFSA is to protect and promote the health, safety, and well being of the children of the District of Columbia through public and private partnerships focused on strengthening and preserving families, and to achieve permanence for the children with services that ensure cultural competence, accountability, and professional integrity. CFSA's goals are to: (1) prevent further abuse and neglect; (2) strengthen parents' capacity to care for their children; (3) assure that children receive adequate care; (4) prevent out-of-home placement when appropriate; and (5) achieve permanence for children through reunification, kinship care, guardianship, or adoption. CFSA provides services that include Intake, Family Services, Out-of-Home Services, Health Care Services, and Community Services as summarized below.

Intake. Intake is the point of entry for all CFSA clients and operates a 24-hour Hotline. It receives reports of suspected child abuse and neglect. Investigative social workers assess abuse and neglect reports to determine whether the allegations are supported.

In Home and Reunification Services. In Home and Reunification Services staff provides services designed to protect children and preserve families. The ultimate goal is to avoid placing children in foster care, but doing so only when it is appropriate. The services provided are intended to reduce risk of harm to the child, build on family strengths, and support family stability. Direct services to families and children include family assessment and evaluation, crisis intervention, counseling, referral for professional evaluations and

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services, as well as court-related services, home visitation, resource coordination, and the unavoidable placement of children.

Out-of-Home Services. Out-of-Home Services are provided to abused and/or neglected children who cannot safely remain in the care of their parents. CFSA provides services that protect children's health and safety while they are in the agency's custody and care. Out-of-Home Services include placement, kinship care, intensive reunification, traditional foster care, adoption, teen services, and abscondence.

Health Care Services. The agency's Health Care Services program, DC KIDS, was established in 1999 to provide comprehensive health care, including medical, mental health, behavioral, and developmental services to children who are in foster care homes or shelters. All providers involved in the program are certified D.C. Medicaid providers and are located throughout the city and metro region to enhance accessibility.

Community Services. The Community Services program was created to address the specific needs of the community and to establish partnerships with community organizations, the courts, law enforcement personnel, mental health professionals, and schools, as well as parents, extended family members, friends, and neighbors.

OBJECTIVES, SCOPE, AND METHODOLOGY

The overall objectives of the audit were to determine whether CFSA: (1) managed the Foster Care Program in an efficient, effective, and economical manner; (2) complied with requirements of applicable laws, rules and regulations, policies, and procedures; and (3) implemented internal controls to ensure the health, safety and welfare of children in youth facilities. Our specific objective for this audit was to determine the adequacy of policies and procedures for documenting, reporting, investigating, and resolving reports of suspected maltreatment incidents[2] for children in the custody of CFSA.

To accomplish our objectives, we reviewed 202 Critical Event Summary/Update Forms (CES forms), unusual incident reports, information extracted from CFSA's computerized management information system (FACES), and other related documents. We conducted interviews with CFSA's management and key personnel, including the Acting Intake and Investigation Administrator, the Abscondence Unit Coordinator, and the Quality Improvement Administrator to gain a general understanding and an overview of the policies and procedures used to manage reports of child maltreatment.

We obtained and reviewed all applicable regulations, policies, and procedures related to child maltreatment. Our efforts were also coordinated with the Center for the Study of Social

[2] Throughout this report, the term "suspected maltreatment incidents" may be referred to as maltreatment incidents, child maltreatment incidents, or incidents.

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Policy (Court Monitor), Council for Court Excellence, the presiding judge of the Superior Court of the District of Columbia Family Court, and the Government Accountability Office.

We also relied on computer-processed data from FACES to provide us with detailed information on child maltreatment incidents and reported investigations. Although we did not perform a formal reliability assessment of the computer processed data, we determined that the hard copy documents reviewed by us generally agreed with the information in the computer processed data. We did not find errors that would preclude use of the computer processed data to meet the audit objective or that would change the conclusions in this report.

Overall, the audit covered the period fiscal year 2001 through fiscal year 2003, was conducted in accordance with generally accepted government auditing standards, and included such tests as we considered necessary under the circumstances.

FINDING AND RECOMMENDATIONS

FINDING: IMPROVING THE IDENTIFICATION, INVESTIGATION, AND REPORTING OF SUSPECTED CHILD MALTREATMENT INCIDENTS

SYNOPSIS

Reports of suspected child maltreatment incidents prepared by CFSA personnel were not properly controlled or accounted for by CFSA at a central location. Foster care providers did not always report suspected maltreatment incidents to CFSA in the required timeframe. Further, official documentation had not been obtained to determine the cause of death for child fatalities or to review and evaluate for quality assurance purposes; and reports of suspected maltreatment incidents accepted for investigation were not always completed by the required completion date.

Also, investigations of suspected maltreatment incidents for children in the custody of CFSA, but physically located in a jurisdiction other than the District of Columbia, had not been monitored for completion, results, and recommendations. Finally, abscondence incidents were not always reported to the CFSA Hotline for evaluation and tracking purposes in FACES.

Factors causing the conditions included a lack of management oversight and internal controls for CES forms, under reporting of suspected maltreatment incidents by foster care providers, and failure to implement statutory and regulatory requirements and CFSA internal policies for the intake, investigation, and reporting of suspected child maltreatment incidents.

As a result, CFSA's inability to effectively manage reports of maltreatment incidents places foster care children at an increased risk of harm. Further, there is no assurance that all child maltreatment incidents are reported in a timely manner, properly documented and/or investigated by CFSA; and that the most effective health and safety services are being provided to the children involved in such incidents.

DISCUSSION

CFSA is responsible for responding to reports of suspected child maltreatment incidents in a thorough, systematic, and timely manner. Our review of CFSA policies, procedures, records, and related documents to support 27 reports of suspected child maltreatment incidents showed that procedures need to be improved to effectively manage suspected maltreatment incident reports and to ultimately provide a safe and productive living environment for children under CFSA's care. Governing criteria are provided in the D.C. Code, District of Columbia Municipal Regulations (DCMR), and CFSA internal policy for intake, investigation, and reporting of suspected child maltreatment incidents.

FINDING AND RECOMMENDATIONS

Applicable Laws, Rules and Regulations, Policies and Procedures. D.C. Code §§ 4-1303, 4-1371, and 4-1422 outline the responsibilities of the Director, CFSA for providing services to children and families serviced by contract, compact, or cooperative agreement[3]. Further, Title 4 addresses requirements for a social services investigation of alleged child abuse and neglect cases; retention of jurisdiction over a child for all matters relating to the custody, supervision, care and treatment of children physically located in another jurisdiction; and the requirement for child fatalities to be reviewed to promote improved public and private systems serving families and children.

Title 29 DCMR Chapters 60, 62, and 63, §§ 6000-6099, 6201-6299, and 6301-6348, provide guidance for the management and administration of foster care services provided by CFSA. Also contained in these regulations are the procedures for the timely reporting of alleged or actual child abuse, neglect, or alleged or actual risk to a child's health or safety.

CFSA procedures for managing and providing oversight of the Hotline, critical events, and investigations of accepted reports of alleged child maltreatment are contained in CFSA's policies entitled: "Hotline; September, 2003;" "Critical Events, January 2002;" and "Investigations, September 2003."

The Hotline. The CFSA Hotline serves as the first line of contact between the community and CFSA for the protection of children. Foster care providers or CFSA staff members who receive information or make personal observations of suspected or actual abuse, neglect, or risk to a child's heath or safety are required to report the incident to the CFSA Hotline. Any suspected incident of child abuse or neglect is required to be reported immediately to CFSA by a foster home provider (parent). Youth residential facilities and independent living programs must provide the Hotline with an oral report immediately and follow-up with a written report within 24 hours.

Critical Event Summary/Update Form. After receiving a report of alleged child maltreatment, Hotline personnel or a child's on-going social worker prepares a Critical Event Summary/Update Form (CES form). The purpose of the CES form is to document the incident and to apprise the CFSA Director of unusual and serious occurrences concerning children in the custody of CFSA. The CES form is prepared for child fatalities, broken bones or burns for children under age 6, missing children under age 12, runaways who are a danger to self or others, and institutional abuse (abuse occurring in a CFSA contracted facility).

Review of Critical Event Summary/Update Forms. Reports of suspected child maltreatment incidents prepared by CFSA personnel had not been properly controlled or accounted for by CFSA at a central location, and had not been properly prepared.

[3] A cooperative agreement is an arrangement made by CFSA with another jurisdiction for child care and placement.

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At the start of our audit, we requested CFSA to provide for our review all CES forms processed during the 3-year period of fiscal years 2001 through 2003. CFSA provided us with 202 CES forms 3 weeks after our initial request. When questioned about the forms that had been provided, CFSA senior officials told us that they were not certain whether the 202 CES forms represented all of the suspected maltreatment incidents reported (on the CES form) for the review period. The 202 CES forms represented incidents associated with 43 fatalities, 33 abscondences, 84 abuse/neglect incidents, 4 suicide attempts, and 38 personal/accidental injury incidents.

CFSA senior officials told us that the delay in providing us with the CES forms was due to the need to obtain the CES forms from various sources and locations. For example, some CES forms were forwarded to CFSA by social workers responsible for individual children, while others were controlled and maintained by a particular unit within CFSA (the Quality Assurance Division). The majority of the reports provided to us were obtained from one CFSA official, who had been assigned to gather and obtain the reports via e-mail from the various sources within CFSA.

From the 202 CES forms, we judgmentally selected 27 for a detailed review in order to evaluate CFSA's policies and procedures for identifying suspected child maltreatment incidents, and to gain an understanding of the investigation and reporting processes. Based upon our review of this information, we found that the CES forms had not been properly prepared. None of the 27 CES forms were signed and dated or contained all the required information on the form. When questioned, CFSA officials could not provide us with an explanation for the forms not being properly prepared.

In addition, as a result of CFSA's inability to properly maintain CES forms in a central location, we were unable to ascertain whether the 202 CES forms provided to us represented all of the maltreatment incidents reported for the review period. Further, there is no assurance that all reports of suspected child maltreatment incidents reported to CFSA had been properly documented and/or investigated.

Table 1 shows a summary by maltreatment category for the reports of child maltreatment incidents selected for our detailed review.

FINDING AND RECOMMENDATIONS

Table 1. Summary of Sample Reports of Suspected Child Maltreatment[1]

Maltreatment Category	Number of Reports
Fatality[2]	6
Abuse and Neglect	14
Abscondence[3]	6
Abduction	1
Total	**27**

[1]Maltreatment category and number of reports data obtained from CFSA Critical Event Summary/Update Forms.
[2]The 202 Critical Event Summary/Update Forms reviewed contained a total of 43 fatality incidents.
[3]The abscondence category includes all children up to 18 years of age.

DCMR Regulations for Reporting Suspected Child Maltreatment Incidents. Title 29 DCMR Chapters 60, 62, and 63, §§ 6002.1(o), 6204.1 and 6304.3 provide that foster care providers or CFSA staff members who receive information or make personal observations of suspected or actual abuse, neglect, or risk to a child's heath or safety are required to report the incident to the CFSA Hotline. Any suspected incident of child abuse or neglect is required to be reported immediately to CFSA by a foster home provider (parent); youth residential facilities and independent living programs must provide the Hotline with an immediate oral report and a written report within 24 hours.

In addition, foster care providers must cooperate with officials investigating all alleged abuse, neglect, or other health and safety issues of facility residents. If a provider believes that a staff member is responsible for committing child abuse or neglect or that a staff member poses an actual risk to a resident's health or safety, the provider must place the staff member on administrative leave or reassign him/her to duties involving no contact with residents, until an investigation is completed.

Providers Timely Reporting of Suspected Maltreatment Incidents. Foster care providers did not always report maltreatment incidents to CFSA in a timely manner. We noted that 7 of 27 CES forms we reviewed indicated that the suspected maltreatment incident occurred for periods ranging from 2 days, to as much as 42 days, prior to the provider reporting the incident to CFSA. The timeliness of an additional 4 CES forms could not be established

FINDING AND RECOMMENDATIONS

because the CES form did not record the date of the incident. CFSA officials did not provide us with an explanation for the 11 untimely/undated cases.

It is disturbing to note that in 1 of the 11 cases that an alleged unwanted advance had been made by a facility employee toward a foster child. The incident was reported to CFSA by an employee of another District agency, rather than a staff member from the facility where the incident occurred. CFSA brought the incident to the attention of the facility administrator, who immediately conducted an investigation. The facility administrator found (through interviews with his staff) that the incident occurred 2 weeks before it was reported to CFSA. The alleged perpetrator of the incident was placed on administrative leave pending the disposition of the investigation by CFSA.

Delays in reporting suspected incidents of child maltreatment by foster care providers impact the start and completion dates of CFSA's investigation of the incident, as well as any necessary actions that need be taken. In addition, delays in reporting incidents make the facility residents more susceptible to harm.

Table 2 shows an analysis of the elapsed time between the identification of a suspected maltreatment incident by a foster care provider and the incident being reported to CFSA**.**

Table 2. Analysis of Time Taken By Foster Care Providers To Report Suspected Incidents of Child Maltreatment to CFSA[1]

Elapsed Days Between Suspected Maltreatment Incident and Provider's Report to CFSA[2]	Number of Incidents
0-1 Day	16
2-5 Days	4
5-10 Days	1
Greater Than 10 Days	2
Incident Date Unknown[3]	4
Total	**27**

[1]Analysis used data reported on CFSA prepared Critical Event Summary/Update Forms.
[2]Actual incident date per the Critical Event Summary/Update Form. Date the provider reported the incident to CFSA is the preparation date of the Critical Event Summary/Update Form.
[3]Date of incident reported by CFSA on the Critical Event Summary/Update Forms as unknown.

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The Child Fatality Review Committee. D.C. Code §§ 4-1371.04(a)(4) and 4-1371.05(a) provide that CFSA is a member of the Child Fatality Review Committee, which is responsible for reviewing the deaths of children who were residents of the District of Columbia and whose families were known to the District of Columbia child welfare system at the time of death or at any point during the 2 years prior to the child's death. The Child Fatality Review Committee examines past events and circumstances surrounding child deaths by reviewing documents of public and private agencies responsible for serving families and children, in an effort to reduce the number of preventable child fatalities. D.C. Code § 4-1371.03(b)(2).

The Chief Medical Examiner. D.C. Code §§ 5-1405(b)(7) and (9) (2001) provides the Chief Medical Examiner the authority to investigate deaths of persons who were wards of the District whose deaths occurred while they were in the legal custody of the District of Columbia. DC Code § 5-1409(b) provides that the Chief Medical Examiner's investigation includes performing an autopsy on the body of a decedent when further investigation as to the cause or manner of death is required or in the public interest. D.C. Code §§ 5 -1412(a) and (b) provide that the Chief Medical Examiner is also responsible for maintaining full and complete records and files for every person whose death is investigated. The Chief Medical Examiner's autopsy records and files for investigated deaths are open to inspection by the Child Fatality Review Committee when necessary for the discharge of its official duties.

Autopsy Reports and Child Fatalities. Our review of the 27 CES forms disclosed that 6 reported incidents involved circumstances that resulted in a child fatality. However, for five of the six incidents, CFSA had not obtained autopsy reports to determine the cause of death or to gather information useful to the prevention of future fatalities. Further, we noted that one of the five autopsy reports had not been obtained for a child fatality incident that occurred on August 21, 2002, during a period when an autopsy report was mandatory for fatalities associated with children in the custody of CFSA. D.C. Law 14-070, effective February 27, 2002-October 10, 2002, is the temporary act that covers the "Mandatory Autopsy for Deceased Wards of the District of Columbia." The one child fatality that occurred on August 21, 2002, is covered by that law.

Our review of the six incidents showed that the Child Fatality Review Committee had completed a Child Fatality Case Review Report for four of the five incidents (for the children in the custody of CFSA). However, for the remaining incident, the Child Fatality Case Review Report has remained incomplete, for a period up to 1 year after the recorded date of the death.

We discussed the lack of official documentation such as an autopsy report for child fatality incidents with CFSA officials who told us that CFSA was not required to obtain an autopsy report in cases involving a child fatality. The officials also stated that the Child Fatality Review Committee results are used to evaluate and improve the quality of CFSA services

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being provided to the child and its family, and that the Child Fatality Review Committee report discusses the cause of a child's death. However, we disagree with CFSA's explanation and rationale for not obtaining an autopsy report for child fatality incidents.

We noted that CFSA officials did not know whether CFSA representatives had obtained autopsy reports (for quality assurance purposes in order to evaluate CFSA services) for the child fatality incidents discussed above. Therefore, we requested CFSA to obtain copies of autopsy reports for the six fatality incidents. As of the date of this audit report, CFSA has provided us with only one autopsy report.

D.C. Code § 4-1303(a-1)(7) and (13) place responsibility on the CFSA Director to "monitor and evaluate" services to abused and neglected children and to take "whatever additional steps necessary" to prevent child abuse and neglect. Therefore, in our opinion, the CFSA Director should obtain an autopsy report for all child fatality incidents to more effectively monitor and evaluate services to children in their custody. Furthermore, without the results of official documentation such as an autopsy report, CFSA is not in the best position to determine whether circumstances at a facility or of a foster care provider contributed to the abuse or neglect of the child.

The following three incidents demonstrate the need for concern about the lack of autopsy reports:

- On December 5, 2002, the body of a 7-month old child was found lying between the bed and the wall at a facility for teen mothers. The detective investigating the fatality suspected that the cause of death was suffocation. However, the detective also stated that the actual cause of death could not be determined, until the completion of a formal autopsy.

- The preliminary findings developed by the Chief Medical Examiner's Office indicate that the cause of death for a 3-month-old child on January 25, 2003, was most likely attributed to Sudden Infant Death Syndrome. Further, CFSA investigators concluded that the child's death was not due to neglect or abuse, although the mother is a known drug user and has a history of abuse and neglect with CFSA. However, the official cause of death remains unknown, because the Chief Medical Examiner had not completed the autopsy requested by the CFSA investigator.

- A 5-month-old child (whose death occurred on July 17, 2003) was treated at a hospital that concluded that the child's death appears to have been the result of respiratory arrest and that there was no evidence or a sign of trauma. However, we noted that the parents of the child had a prior report of a maltreatment incident with CFSA. The actual cause of death remains unknown because the Chief Medical Examiner's Office had not completed the autopsy requested by the hospital.

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We did not inquire as to whether a backlog of autopsy cases existed at the Chief Medical Examiner's Office. Rather, our audit procedures focused on CFSA's efforts to obtain autopsy reports. To date, CFSA has not provided the OIG with documentation to show that an autopsy report had ever been requested for five of the six child fatalities we reviewed (which include the three fatalities discussed above that occurred 18 to 24 months ago).

Investigating Accepted Hotline Reports. CFSA investigates accepted Hotline reports of child maltreatment incidents for foster children located in the District of Columbia. The investigations are initiated by establishing face-to-face contact with the alleged victim within 24 hours of receipt of the report. The investigation includes an assessment of safety and risk for not only the alleged child victim, but also for all of the children residing in the home.

Review of Timeliness for Completing Investigations. Investigations of suspected maltreatment incidents accepted for investigation by the CFSA Hotline supervisor had not been completed by the assigned investigation unit's required completion date. Our review of the 27 CES forms showed that 12 reported maltreatment incidents resulted in investigations, which were required to be completed within 30 calendar days after initial contact with the victim. However, we found that only 5 of the 12 investigations were completed within the 30-day period, and that number of days to complete the 12 investigations ranged from the required 30 days to over 90 days.

Table 3 shows an analysis of suspected maltreatment incidents accepted by CFSA's Hotline for investigation and the number of days expended to complete each investigation.

Table 3. Analysis of the Days Expended by CFSA to Complete Suspected Maltreatment Investigations

Elapsed Days Between Investigation Initiation And Completion Dates[1]	Number of Investigations
0-30 Days	5
31-60 Days	5
61-90 Days	1
Greater Than 91 Days	1
Total	**12**

[1]The investigation initiation date is determined from the Investigation Summary Report or the Investigation Case/Client Contact screen in FACES. The investigation end date was determined from the Investigation Closure screen per FACES.

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Investigations had not been initiated by CFSA for the remaining 15 maltreatment incident reports because:

- 7 reports were for suspected maltreatment incidents occurring in jurisdictions other than the District of Columbia (for which the host jurisdiction investigates);
- 7 reports were for foster children who had absconded from a facility which CFSA does not investigate; and
- 1 report was investigated by the Metropolitan Police Department, prior to referral to CFSA.

Failure to complete investigations in a timely manner results in children being more susceptible to harm. In addition, it can result in delays in providing adequate care and needed services. Further, a lack of investigation or untimely investigation fails to identify providers found to be operating a facility that poses harm to children or otherwise does not provide the care and protection required by law and regulation. These facilities may continue to provide licensed care when the facilities' licensure should be questioned or withdrawn.

The Placement of Children in Other Jurisdictions. D.C. Code § 4-1422 grants the Mayor authority to enter into and execute a compact with another jurisdiction for the interstate placement of foster children. The District retains "jurisdiction over the child sufficient to determine all matters that relate to the custody, supervision, care, treatment, and disposition of the child that it would have had if the child had remained in the [District of Columbia.]" D.C. Code § 4-1422 art. V. (2001*)*. This jurisdiction remains until the child is adopted, reaches the age of majority, becomes self-supporting, or is discharged with the concurrence of CFSA. *Id.*

Investigation of Suspected Maltreatment Incidents Referred to Other Jurisdictions. Investigations of suspected maltreatment incidents for children in the custody of CFSA, but physically located in a jurisdiction other than the District of Columbia, had not been monitored for completion, results, and recommendations.

Our review of the 27 CES forms indicated that 7 maltreatment incidents had been reported for a child that resided in a foster care facility or home located in another jurisdiction. Each report had been accepted by the CFSA Hotline, assigned a FACES tracking number, and referred for investigation to the jurisdiction where the suspected maltreatment incident occurred. We noted that five of the children resided in foster care facilities located in Maryland, one in a foster care home in Virginia, and the remaining child in a foster care facility located in Pennsylvania.

However, based upon our review of CFSA's records, we could not determine the current status for any of the seven investigations. We provided CFSA the seven CES forms and

FINDING AND RECOMMENDATIONS

requested information on the current status of each investigation. As a result of our request, CFSA determined that:

- 3 investigations were screened out by the jurisdiction performing the investigation as being unsubstantiated;
- 2 investigations were completed by the investigating jurisdiction, but results and recommendations had not been provided to CFSA; and
- the status for the remaining 2 investigations was not known.

Table 4 shows our analysis of the investigation status for the seven suspected maltreatment incidents referred to other jurisdictions for investigation.

Table 4. Analysis of Suspected Maltreatment Incidents Referred to Other Jurisdictions for Investigation

Foster Care Client	Date of Suspected Maltreatment Incident[1]	Jurisdiction Investigation Referred To	Status of Investigation
A	Unknown	Maryland	Allegation Screened Out[2]
B	8/02/2002	Maryland	Allegation Screened Out[2]
C	Unknown	Pennsylvania	Unknown
D	Unknown	Virginia	Unknown
E	Unknown	Maryland	Allegation Screened Out[2]
F	1/21/2003	Maryland	Investigated
G	1/22/2003	Maryland	Investigated

[1]Date of maltreatment incident reported per the Critical Event Summary/Update Form.
[2]Investigating jurisdiction considers the allegation to be unsubstantiated.

Failure to actively monitor reports of suspected maltreatment incidents referred to another jurisdiction for investigation does not provide assurance that investigations are completed in

FINDING AND RECOMMENDATIONS

an efficient and timely manner; and that the child is being provided foster care services in a healthy and safe environment.

Investigating and Tracking Abscondence Incidents Reported to the Hotline. Title 29 DCMR §§ 6024.1, 6204.6, and 6304.3 provide that the CFSA Hotline accept and forward for a protective service investigation all information indicating an actual or alleged risk to a foster child's health or safety. Also, in accordance with CFSA procedures, incidents involving the abscondence of a child (in the custody of CFSA) are referred to protective services when: (1) a child is 12 years of age and under; (2) the child who absconded presents a danger to self or others; (3) it concerns the abscondance of several children from one facility; or (4) a child has been abused in out-of-home care. In addition, the CFSA Hotline also accepts and refers for investigations the report of a runaway child, although the child is not under the custody of CFSA. The report of a runaway child that is not under CFSA custody is referred to and handled by the child's on-going social worker.

Review of Abscondence Incidents. Abscondence incidents were not always reported to or accepted by the Hotline for investigation purposes. Our review of the 27 CES forms showed that 6 were for reports of children who had absconded from their foster care provider; however, the circumstances related to the incident had not been investigated.

We noted that four of the six incidents were not reported to the Hotline for the assignment of an investigation number for tracking purposes in the FACES. We also noted that of the six incidents of abscondence, the remaining two were reported to the Hotline as an Information and Referral action. Although the six abscondence incidents were not investigated, we noted that (per FACES) for one of the six incidents, the child's on-going social worker did not refer the incident to CFSA's Abscondence Unit as required.[4]

We determined that the six reports had not been investigated because (in accordance with CFSA's procedures) an abscondence incident for a child over age 12 is considered to be an Information and Referral reporting action by the Hotline reporting process. However, the failure to investigate all abscondence incidents does not provide assurance for the safety and well being of foster care children located in the District of Columbia and surrounding jurisdictions. In addition, an abscondence incident can escalate and result in a more tragic outcome for a child, as discussed below.

Abscondence Incidents Resulting in Maltreatment. We noted that 3 of the 27 CES forms reported incidents that began with the abscondence of the child, resulted in a subsequent maltreatment investigation being conducted (as a result of a child's death, abuse, or neglect that occurred while in abscondence). For example, CFSA's records indicate that a child

[4] The Abscondence Unit obtains a custody order for the runaway child and notifies a contracted outreach worker to locate and counsel the child to return from abscondence. All actions taken by the Abscondence Unit are entered into Faces.

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absconded from a foster care provider five times; however, during the 5th abscondence, which lasted for over 1 year, the child was found fatally wounded. *See* MAR No 04-A-14 (Exhibit B).

As a result of our review of abscondence incidents, we issued Management Alert Report No. 04-A-14 to CFSA on May 10, 2004. In that report, we recommended that all incidents of abscondence obtained from CFSA foster care providers be reported to and recorded in the Hotline. We also recommended that CFSA evaluate and investigate, when warranted, all incidents of abscondence reported to the CFSA Hotline. Prior to issuing this draft report, CFSA agreed to examine the process for identifying and processing abscondence incidents. Therefore, the action taken by CFSA is sufficient and no recommendation is needed.

Conclusion. A recent report issued by the court monitor shows that CFSA has made significant improvements in the areas of individual social worker caseloads, case plans, social worker visits, foster care facility licensing, and youth in congregate care. However, we believe that CFSA needs to improve its process for identifying, reporting, and investigating suspected maltreatment incidents for children in foster care facilities located in the District of Columbia and other jurisdictions.

Although CFSA has developed policy for critical events, the Hotline, and suspected maltreatment investigations, CFSA needs to develop, update, or reemphasize policy and procedures for reporting and investigating suspected maltreatment incidents that address the following:

- Collecting and controlling CES forms in a central location;
- Investigating maltreatment incidents for children located in the District of Columbia and other jurisdictions to ensure that they are monitored and completed in required timeframes;
- Documenting the cause of death for child fatality incidents for use by CFSA to improve services provided to foster children; and
- Oversight of foster care facilities to ensure that suspected incidents of child maltreatment are reported to CFSA in required timeframes.

RECOMMENDATIONS

We recommended that the Director, Child and Family Services Agency:

1. Require the collection and control of Critical Event Summary/Update forms be in a central location for all reported suspected incidents of child maltreatment.

FINDING AND RECOMMENDATIONS

2. Reemphasize to all foster care providers the requirement to report allegations of child maltreatment to CFSA no later than 24 hours after identifying a suspected incident.

3. Scrutinize all maltreatment allegations from 2001 to date and obtain official documentation, such as an autopsy report, if available, on the cause of death of any child in CFSA's care.

4. After scrutinizing all maltreatment reports, screen all child care providers to assure that they are adhering to child care standards and take action to suspend licensure of those facilities involved in repetitive child fatalities or negligent care.

5. Ensure that investigations of maltreatment incidents that are accepted by the Hotline be completed within 30 days after the initial contact with the alleged maltreated child.

6. Ensure that investigations of alleged maltreatment of children in CFSA's care who are located in another jurisdiction and are referred to that jurisdiction for investigation are actively monitored to obtain results and recommendations for action purposes.

7. Report child care providers involved in repeated cases of child fatalities or negligent care to the appropriate licensing authority.

CFSA RESPONSE (Recommendation 1)

CFSA responded to the recommendation stating that they do centralize the collection of all reported suspected incidents on child maltreatment through the Hotline, which operates 24 hours per day, 7 days per week. Specifically all allegations of abuse or neglect are required to be reported to the Hotline and recorded in FACES.

OIG COMMENT (Recommendation 1)

CFSA did not provide an adequate response to Recommendation 1, which requires collection and control over the Critical Event Summary/Update forms to be in a central location. Accordingly, we request that CFSA reconsider its position and provide an updated response within 60 days from the date of this report. The full text of CFSA's response is included at Exhibit F.

CFSA RESPONSE (Recommendation 2)

CFSA concurred with the recommendation and stated that they continue to reinforce the requirement for all foster care providers to report allegations of child maltreatment to CFSA no later than 24 hours after identifying a suspected incident. Specifically, CFSA

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has established the Office of Training Services which provides trainings to provider agency staff, and incorporates reporting requirements in the pre-service and on-going training for foster parents. Additionally, the Office of Licensing and Monitoring, through its monitoring function, regularly reminds the provider agencies of their reporting obligations and reinforces the reporting requirement in their monthly provider meetings.

OIG COMMENT (Recommendation 2)

CFSA corrective actions are responsive and meet the intent of the recommendation.

CFSA RESPONSE (Recommendation 3)

CFSA stated that they request preliminary and final autopsies on every child fatality victim and ensure their availability. However, CFSA recognizes that there remains a backlog of autopsies for 2002 and 2003 at the Medical Examiner's Office, that the three cases cited in the draft report are part of the backlog, and that this has hampered CFSA's ability to complete fatality review reports. Nevertheless, CFSA stated that autopsy results have been obtained in all cases where the autopsy has been completed, and continues to receive reports and updates regularly. CFSA stated that it maintains a database to track child fatality information.

OIG COMMENT (Recommendation 3)

The CFSA response meets the intent of the recommendation.

CFSA RESPONSE (Recommendation 4)

CFSA partially agreed with the recommendation, stating that they do not license child care providers providing day care services and thus cannot suspend licenses. However, CFSA has taken a number of steps to improve child safety, which includes providing training to child care providers on mandatory reporting requirements and educating them about child abuse and neglect. Further, CFSA is investigating incidents of alleged maltreatment by child care providers, and upon request of a child care provider, reviewing applicants for employment in child care settings to determine if their names appear on the Child Protection Registry.

OIG COMMENT (Recommendation 4)

Based upon CFSA'S response that they do not license child care providers providing day care services and thus cannot suspend licenses, an additional recommendation is warranted. Therefore, we are amending this report to include an additional recommendation (Recommendation 7), requiring CFSA to report child care providers

FINDING AND RECOMMENDATIONS

involved in repeated cases of child fatalities or negligent care to the appropriate licensing authority.

CFSA RESPONSE (Recommendation 5)

CFSA concurred with this recommendation and have undertaken a number of initiatives to ensure that investigations of maltreatment incidents are completed within 30 days after initial contact with the alleged maltreated child. These initiatives include hiring a new Intake and Investigations Administrator and temporary staff to work on the backlog, creating a unit of experienced investigators, who are focusing completely on the backlog, and developing action plans for investigators who need to improve performance.

OIG COMMENT (Recommendation 5)

CFSA corrective actions are responsive and meet the intent of the recommendation.

CFSA RESPONSE (Recommendation 6)

CFSA concurred with the recommendation and stated that they are formalizing a process with other jurisdictions to actively monitor and obtain results and recommendations for investigations of alleged maltreatment of children in CFSA's care, who are located in another jurisdiction.

OIG COMMENT (Recommendation 6)

CFSA corrective actions are responsive and satisfy the intent of the recommendation.

SUMMARY OF POTENTIAL BENEFITS RESULTING FROM AUDIT

Recommendation	Description of Benefit	Amount and Type of Benefit	Status[5]
1	Compliance and Internal Control. Collect and control Critical Event Reporting Forms in a central location.	Nonmonetary.	Unresolved
2	Compliance and Internal Control. Reemphasize to foster care providers the requirement to report incidents of suspected child maltreatment to CFSA with 24 hours of the incident.	Nonmonetary.	Closed
3	Program Results. Obtain and document for quality assurance purposes the cause of death for the fatality of a child who is in CFSA's care.	Nonmonetary.	Closed
4	Compliance and Internal Control. Screen childcare providers for adherence to child-care standards and take appropriate action where warranted.	Nonmonetary.	Closed
5	Program Results. Ensure that investigations of alleged incidents of child maltreatment are completed within 30 days of acceptance by the CFSA Hotline.	Nonmonetary.	Closed

[5] This column provides the status of a recommendation as of the report date. For final reports, "**Open**" means Management and the OIG are in agreement on the action to be taken, but action is not complete. "**Closed**" means management has advised that the action necessary to correct the condition is complete. "**Unresolved**" means that management has neither agreed to take the recommended action nor proposed satisfactory alternative actions to correct the condition.

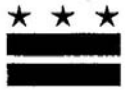
SUMMARY OF POTENTIAL BENEFITS RESULTING FROM AUDIT

Recommendation	Description of Benefit	Amount and Type of Benefit	Status
6	Program Results. Ensure that child maltreatment investigations referred to other jurisdictions are actively monitored to obtain results and recommendations for action purposes.	Nonmonetary.	Closed
7	Compliance and Internal Control. Report child care providers involved in repeated cases of child fatalities or negligent care to the appropriate licensing authority.	Nonmonetary.	Open

MANAGEMENT ALERT REPORT

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



May 10, 2004

Brenda Donald Walker
Interim Director
Child and Family Services Agency
400 6th Street, S.W.
Washington, D.C. 20024

Subject: Incidents of Abscondence by Children in the Custody of the Child and Family Services Agency (CFSA)

Dear Mrs. Walker:

The purpose of this Management Alert Report (MAR No. 04-A-14) is to inform you of a potential health and safety issue that was identified during our ongoing Audit of the Child and Family Services Agency's (CFSA) Management of the Foster Care Program (OIG No. 03-2-11RL) that requires your immediate action. During the course of our review of 27 reports of abuse, neglect, other risks to residents' health and safety, and unusual incident reports, we found that incidents of abscondence for children in CFSA's care were not always reported to the Child Abuse and Neglect Hotline (Hotline) or investigated to ensure the children's well-being, safety, and protection. Six of the 27 reports of abuse, neglect, other risks to residents' health and safety, and unusual incidents were for incidents related to abscondence.

We emphasize that our review of reports of abuse, neglect, other risks to residents' health and safety, and unusual incidents is incomplete at this stage. In this regard, we look forward to continuing our working relationship with the staff of CFSA in an effort to bring closure to this issue, and request that you respond to this MAR within 10 business days.

SYNOPSIS. Our review of 27 reports of abuse, neglect, other risks to residents' health and safety, and unusual incidents that involve children in CFSA's care, showed that CFSA does not evaluate these abscondence incidents in a thorough and systematic manner. Specifically, after the preparation of the required Critical Event Reporting Forms by the CFSA Hotline worker or a child's on-going social worker, the abscondence incidents associated with these reports were not always assigned a referral number for tracking purposes in CFSA's computerized management information system (FACES).

717 14th Street, N.W., Washington, D.C. 20005 (202) 727-2540

MANAGEMENT ALERT REPORT

The review also showed that when an incident of abscondence was assigned a referral number, CFSA did not evaluate the incident because CFSA categorizes an abscondence incident as an Information and Referral action, which does not require an investigation. Failure to investigate these types of incidents places these children at greater risk for subsequent maltreatment and does not provide assurance for the safety and well-being of foster care children in the care of CFSA.

DISCUSSION. The Hotline serves as the first line of contact between the community and CFSA for the protection of children. The Hotline receives and documents information from the reporting source; provides information and referrals for preventative services; determines whether a report will be accepted for assessment or investigation; establishes a priority for an accepted report; researches agency records and collateral sources; and promptly assigns reports for assessment or investigation or for other agency and community services.

The Critical Event Reporting Form is completed by Hotline staff or the child's on-going social worker for child fatalities or critical incidents; broken bones or scalding burns in children under the age of 6; missing children under the age of 12; runaways who are a danger to self or others; and institutional abuse. The purpose of this form is to ensure that the CFSA's Director's Office is apprised of unusual and serious occurrences involving children in CFSA's care.

An Information and Referral action is completed by a CFSA Hotline worker to report an incident involving a CFSA foster child. The information report contains data collected on a CFSA foster child located in the District of Columbia and is used for incidents other than abuse and neglect, such as abscondences. Because the report is retained for informational purposes only, it does not result in a CFSA investigation. The referral report is used for abuse and neglect incidents involving CFSA foster children located in another jurisdiction, which are referred to that jurisdiction for appropriate evaluation and action.

As a part of our audit, we reviewed 27 Critical Event Reporting Forms containing information submitted by foster care providers related to an allegation of neglect, abuse, or an unusual incident. Six of the 27 Critical Event Reporting Forms pertained to children who absconded from their foster care provider.

We noted that four of the six incidents of abscondence had not been reported to the Hotline for the assignment of a referral number for tracking purposes in FACES. We also noted that of the six incidents of abscondence, the remaining two were reported to the Hotline as an Information and Referral action. Therefore, the six abscondence incidents were never evaluated and/or investigated by CFSA.

MANAGEMENT ALERT REPORT

The abscondence of children from foster care providers can result in maltreatment to the absconded children. We found that in addition to the 6 abscondence incidents, 3 of the remaining 21 Critical Event Reporting Forms contained information on other incidents that began with the abscondence of a foster care child, and resulted in one death and two alleged maltreatment investigations being conducted by CFSA or another jurisdiction.

An upcoming OIG report is planned to address reports on abuse, neglect or other risks to residents' health and safety, and unusual incidents in more detail and will include the results of our review of the other 21 Critical Event Reporting Forms.

CONCLUSION. It is our opinion that the abscondence of children in CFSA's care, regardless of age, should be reported to and evaluated by the Hotline process as a potential child maltreatment (risk to the child's health and safety) case rather than processing the abscondence incident as an Information and Referral action not requiring an investigation. This would allow the Hotline process to evaluate the situation and determine whether an investigation is warranted; assure that required quality services are being provided to foster care children; and identify patterns of risk or other systemic issues requiring the attention of CFSA management.

Recommendations.

We recommend that the Director, Child and Family Services Agency:

1. Require all incidents of abscondence obtained from CFSA foster care providers to be reported to and recorded in the Hotline.
2. Evaluate and investigate, when warranted, all incidents of abscondence reported to the CFSA Hotline.

Closing.

Please provide your comments and response to the recommendations by May 25, 2004. Your response should include actions planned or taken, target dates for completing actions, and reason(s) for any disagreements with the issue and recommendations. You may suggest alternative actions that would resolve the conditions disclosed in this report. **Our intention is to limit distribution of this Management Alert Report until comments are received. Therefore, please circulate it only to those personnel who will be directly involved in preparing your response.**

MANAGEMENT ALERT REPORT

Should you have questions concerning this report or desire a conference before preparing your response, please contact William J. DiVello, Assistant Inspector General for Audit, or me at 202-727-2540.

Sincerely,

Austin A. Andersen
Interim Inspector General

AAA/ws

cc: Mr. Robert C. Bobb, City Administrator, District of Columbia
Ms. Lori E. Parker, Deputy Mayor for Children, Youth, Families, and Elders

CFSA'S INITIAL RESPONSE TO THE MANAGEMENT ALERT REPORT

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

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IN REPLY REFER TO:

May 25, 2004

Austin A. Andersen
Interim Inspector General
717 14th Street N.W.,
Washington, D.C. 20005

Re: Incidents of Abscondence by Children in Custody of CFSA
MAR No. 04-A-14

Dear Mr. Andersen:

Thank you for your letter of May 10, 2004 concerning the issue of how Child and Family Services Agency (CFSA) addresses incidents of abscondence by children in its custody. We recognize that we need to work with our partners to reduce the number of abscondences and to improve how quickly we find children who have absconded. Your thoughtful comments about our processes will be helpful as we address these issues in more detail over the next few weeks.

As you are aware, under CFSA's current process, incidents of abscondence are reported in several ways. During normal business hours, the provider immediately notifies the police and the social worker, who assesses the information to determine if the matter needs to be referred for an investigation because the worker believes the facts suggest the child has been neglected or abused or is at imminent risk of maltreatment. The worker likewise is responsible for promptly seeking a custody order and informing the parents, GAL and judge of the child's abscondence. If the incident occurs after hours or on weekends, the provider is expected to notify the police and also report the incident to the Hotline, which then notifies the worker so that he/she may make the assessments and notifications as indicated above. In all cases involving youth residential facilities, independent living programs, and provider foster homes, pursuant to DC regulations, an unusual incident report is also completed and forwarded to our Office of Licensing and Monitoring. Monitors review each UI report, and, verify the social worker has been notified and that if there is a suggestion of abuse and neglect, that it has been called into the Hotline. Additionally, UI reports are considered by the Licensing Division at the time of relicensing, and if a monitor identifies issues that might affect a provider's licensing status before that time, the monitor will refer it to the Licensing Division. Additionally, we now can track unusual incidents by type, as well as by vendor, which will allow us to look for trends and do an analysis of such trends.

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CFSA'S INITIAL RESPONSE TO THE MANAGEMENT ALERT REPORT

As we considered your comments and recommendations, we thought it would be helpful in informing our response to learn about the practices in other jurisdictions. Interestingly, we learned that Ohio, Connecticut, Illinois, Pennsylvania, Utah and North Carolina all handle the reporting of abscondences in a manner similar to the procedures we follow, with immediate reports to the police and the completion of a written incident report. None of these jurisdictions seems to require reporting to a central Hotline in every case, but rather only when the reporter believes there is an indication of imminent risk to the child. We also learned that some of these jurisdictions differentiate between late returns and abscondences, for example, not identifying a child as in abscondence until he/she is over four hours late from returning from a pass.

This information, when considered with your comments and recommendations, has led us to conclude that we need to examine our process in more detail over the next few weeks before we can formally respond to your recommendations, and therefore I have asked a work group already dealing with unusual incidents to look at this issue immediately. Certainly, we share the goals which underlie your recommendations, that children's safety is paramount, and that children who are in abscondence status are potentially at risk of harm. Therefore, we will be reviewing our current processes to ensure they meet our shared goals - - that CFSA is promptly informed when children are missing from their placements; that CFSA has a clear and uniform process to assess immediately the risks to the individual child who is in abscondence and identify those cases where an investigation is appropriate; that CFSA has a process which leads to prompt notification to all relevant parties (the police, social workers, parents, GALs, and judges) when a child is in abscondence; that all providers and CFSA workers clearly understand and comply with the process; and finally, that CFSA is able to capture timely and accurate data about abscondences, so that it can appropriately analyze the data. Your letter will be provided to this work group for its information and consideration. We anticipate that it will take us until early July, 2004 to complete this work. Once we have done so, we will advise you of what actions we will take.

Thank you for your attention to this matter. We appreciate your concern for the safety of children in our custody, and your comments and recommendations will provide us guidance as we move quickly to review our procedures.

Sincerely,

Brenda Donald Walker

Brenda Donald Walker, Interim Director
Child and Family Services Agency

cc: Robert C. Bobb, City Administrator, District of Columbia
Lori E. Parker, Deputy Mayor for Children, Youth, Families and Elders

CFSA'S FINAL RESPONSE TO THE MANAGEMENT ALERT REPORT

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency
Office of Director

August 5, 2004

Austin A. Anderson
Interim Inspector General
717 14th St., N.W.
Washington, DC 20005

Re: Incidents of Abscondence by Children in Custody of CFSA

Dear Mr. Anderson:

I am pleased to be writing to you to follow up on your letter of May 10, 2004 and our initial response thereto. As indicated in my letter of May 25, 2004, and based on your articulated concerns, I convened an Agency workgroup to review your letter and recommendations. The workgroup not only reviewed the current Agency policy and protocols related to the handing of abscondences, but also reviewed the policies and procedures of other jurisdictions to compare them with our own practices.

In evaluating your recommendations, the workgroup first considered how we define "absondence" and how that definition compares with definitions used on other comparable jurisdictions. As abscondence is presently defined by CFSA, a child who was simply unaccounted for from the home for more than one hour is treated the same as a child with a history of absconding with days unaccounted for. In examining your recommendations, the work group concluded that the definition of what constitutes an abscondence needs refinement, and thus we are working to tighten the definition of an abscondence. We are still evaluating several option, but the impetus behind our evaluation is straightforward: by distinguishing a child who is simply late for a curfew from a child who has intentionally run from a placement, we will be better able to address the needs of the individual child. We project this will have a twofold benefit. First, the needs and issues of a child who runs away from a placement are different from one who misses a curfew. By distinguishing these incidents, we will be better able to serve both populations. Second, by tightening the definition of abscondence, we will be able to emphasize the importance of the issue and directly address those children who are actually in "abscondence", without diluting the resources we use to locate them. As we finalize the definition, we will amend the relevant regulations to clearly reflect the definition.

With that backdrop, your letter contained two specific recommendations regarding changes to our abscondence/Unusual Incident reporting policy and practice. First, you recommended that we require all incidents of abscondence obtained from CFSA foster care

Brenda Donald Walker, Acting Director
400 6th St. SW, Washington, DC 20024

CFSA'S FINAL RESPONSE TO THE MANAGEMENT ALERT REPORT

providers to be reported and recorded in the Hotline. Second you recommended that we evaluate and investigate, when warranted, all incidents of abscondence reported to the hotline. We agree, in principal, with both of those recommendations.

First, over the next several months, we will be implementing the first recommendation by requiring all UI reports to be reported and recorded through the Hotline. This will require an amendment to our training procedures, as well as updates to the fields on our FACES screens. However, once implemented, this will allow CFSA to create an efficient and accurate data collection and tracking process. By having it reported and recorded by the Hotline into FACES, this will also allow programs and units across the Agency to monitor UI reports on a regular basis.

With respect to your second recommendation, we plan to develop a procedure for evaluating and where warranted, investigating reports of abscondence. We anticipate opening an investigation in cases where there are allegations of abuse or neglect within the report, or if, after studying the data, we identify patterns or other information suggestive of abuse or neglect. As we fully implement the use of the Hotline in reporting and FACES in tracking, we will certainly track the progress and evaluate whether adjustments may be needed.

We are further tightening our attention to the issue of abscondence by drafting clear Agency protocols on this issue. While the protocols will incorporate much of our existing process for evaluating and investigating incidents of abscondence, we also plan to provide for case staffing within a week of the abscondence under specific circumstances. The staffing will include, among others, the assigned social worker, supervisor, and other appropriate individuals. The purposes of the staffing will be three-fold: 1) discuss the status of the location efforts, 2) discuss the plans for the child's return, 3) review the child's placement and other relevant clinical information and 4) discuss strategies to prevent future abscondences. We are hopeful that this multi-faceted, umbrella approach will have positive impacts relating to the safety, well being and stability of children in our care.

I again want to thank your for your attention to this matter. Your suggestions were most helpful, and will continue to inform much or our planning and discussion surrounding the population of absconding youth – a very challenging population. There will certainly been a need to reassess and tighten, but believe the initiatives outlined will benefit our children. We will keep you apprised of our progress, and if you have further thoughts, please do not hesitate to communicate with me further on this issue.

Best regards,

Brenda Donald Walker/gmm

Brenda Donald Walker
Acting Director, CFSA

cc: Mr. Robert Bobb, City Administrator, District of Columbia
Mr. Neil Albert, Deputy Mayor for Children, Youth, Families and Elders

Brenda Donald Walker, Acting Director
400 6th St. SW, Washington, DC 20024

DEPUTY MAYOR'S RESPONSE TO CFSA'S FINAL RESPONSE TO THE MANAGEMENT ALERT REPORT

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Deputy Mayor for Children, Youth, Families and Elders

Neil O. Albert
Deputy Mayor

August 12, 2004

Brenda Donald-Walker, Acting Director
Child and Family Services Agency
400 6th Street, S.W. 5th Floor
Washington D.C. 20024

Re: Incidents of Abscondence by Children in Custody of CFSA

Dear Director ~~Donald~~-Walker: Brenda

This letter is in response to your August 5, 2004 correspondence to the Interim Inspector General, concerning the efforts underway at the Child and Family Services Agency (CFSA) to address the very urgent need to take reports, investigate and locate children and youth who abscond from CFSA placements. I am sure you agree that any child under the custody of CFSA who has absconded or is missing from a CFSA placement is a child at-risk, warranting an investigation.

In terms of implementing the Inspector General's recommendation that all incidents of abscondence obtained from CFSA foster care providers be recorded and reported in the Hotline and entered into FACES, please provide the date by which this will occur. In your response, please also include the specific timeframe for training foster care providers on their obligation to immediately report such incidences to the Hotline.

Clear agency protocols on the issue of abscondence should be developed as expeditiously as possible. CFSA Hotline and intake workers should immediately receive training on implementing the revised protocols. The protocols should address the opening of an investigation into a report that a child has absconded from a CFSA placement. Please provide the timeframe for completion of such protocols.

Thank you for your attention to this matter.

Sincerely,

Neil O. Albert

cc: Robert C. Bobb, City Administrator/Deputy Mayor
Austin A. Anderson, Interim Inspector General

1350 Pennsylvania Avenue NW, Suite 303, Washington, D.C. 20004 (202) 727-8001

CFSA'S RESPONSE TO DRAFT REPORT

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Child and Family Services Agency

Office of the Director

February 14, 2005

Austin Anderson
Interim Inspector General
Office of the Inspector General
717 14th St. N.W.
Washington, DC 20005

Dear Mr. Anderson:

Thank you for the opportunity to comment on your "Audit of Suspected Incidents of Foster Children Maltreatment reported to the District of Columbia Child and Family Services Agency." The management audit covers FY01 through FY 03 (October 1, 2000 through September 30, 2003), which includes a period when the Agency was managed by the court appointed receiver. CFSA has undertaken across-the-board reforms since emerging from receivership in June 2001, and we have been aggressively addressing each of the issues identified in the audit. In fact, the pace of our reform is such that the Agency today looks far different than it did just 15 months ago, the end of the period covered by the audit.

While we generally agree with your comments and recommendations, we want to provide updated information to reflect the current progress on the issues. Additionally, we have identified a few statements in the audit which we believe need correction.

1) Require collection and control of Critical Event Summary/Update forms be in a central location for all reported suspected incidents of child maltreatment.

CFSA does centralize the collection of all reported suspected incidents on child maltreatment through our Hotline, which operates 24 hour per day, 7 days per week. Specifically:

- All allegations of abuse or neglect, including those stemming from incidents within a foster home or provider facility, are required to be reported to the Hotline and recorded in FACES.
- Allegations of abuse or neglect in a foster home or congregate care facility are investigated by a specially trained institutional abuse investigations unit. CFSA is developing a protocol to ensure those investigations are coordinated with our licensing unit.
- CFSA also tracks a broader category of unusual incidents which may affect a child in foster care or a provider, but are not allegations of abuse or neglect (e.g., child falls at school and needs stitches). Unusual incident reports are reviewed by the Office of Licensing and

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CFSA'S RESPONSE TO DRAFT REPORT

Monitoring (OLM), which prepares periodic reports by type and by category of provider. (See attached sample report.)

2) Reemphasize to all foster care providers the requirement to report allegations of child maltreatment to CFSA no later than 24 hours after identifying a suspected incident.

CFSA continues to reinforce this requirement for all foster care providers. Specifically, CFSA has:

- Established the Office of Training Services which coordinates mandatory reporter trainings in the community. The Administration has provided 57 trainings for provider agency staff.
- Incorporated reporting requirements in our preservice and on going training for foster parents.
- OLM, through its monitoring function, regularly reminds the provider agencies of their reporting obligations (which are also delineated in their contracts), and reinforces it in their monthly provider meetings.

3) Scrutinize all maltreatment allegations from 2001 to date and obtain official documentation, such as autopsy reports, if available, on the cause of death of any child in CFSA care.

CFSA reviews the case of every fatality of a child in our care or who was known to CFSA within the preceding four years.[1] Our review process has two facets: CFSA operates its own internal child fatality review committee and we participate in the city-wide child fatality review committee. Our internal committee convenes immediately upon being notified of a child fatality, reviews the quality of practice and develops a comprehensive report with recommendations. The city-wide fatality committee usually does not review a fatality until after CFSA's internal review is completed. It is true that oftentimes there are long delays in obtaining autopsy reports, and this has been identified by the city-wide committee as an issue for the Office of the Chief Medical Officer. However, CFSA does routinely get these reports once they are completed.[2]

CFSA has a Child Fatality Review Unit within the Quality Improvement Administration that:

- Maintains a database to track and monitor child fatality information such as demographics, cause of death, location of death (Ward) etc. for all fatalities, whether reported through CFSA's Hotline and/or from the city-wide Child Fatality Review Committee Coordinator.
- Negotiated an agreement with the Metropolitan Police Department (MPD) to *immediately* report all child fatalities to CFSA Hotline, even when abuse may not be the cause of death. This information assists CFSA Intake investigators to evaluate potential and/or immediate /ongoing risks and safety to other children in the home.
- Convenes a critical event meeting the next business day following notification of a death to the Hotline.

[1] Although the draft report correctly notes that DC law only requires us to review deaths known to they system for a two year period prior to the death, the *LaShawn* court order, as modified, requires review for deaths within four years of being known to the child welfare system. Thus, we actually review more fatalities that DC law requires.

[2] Because CFSA may review a case long after the child has been involved with the child welfare system, there are cases where cause of death may not be relevant to practice issues. For example, we may review a death of a 25 year old who aged out of the system four years earlier and died in a car accident. We recognize, however, that in most cases the autopsy report is a critical part of the review.

CFSA'S RESPONSE TO DRAFT REPORT

- Obtains timely information about fatalities through CFSA and MPD's joint investigations fatality cases, particularly when abuse and neglect has been the cause of death. This provides CFSA with the immediate ability to assess the risk to other children, so the Agency can respond appropriately.
- Contacts the city-wide Child Fatality Coordinator at least weekly regarding causes of death, and preliminary and final autopsy reports.
- Requests preliminary and final autopsies on child fatality victims in a timely manner and ensures their availability. We recognize that there remains a backlog of autopsies for 2002 and 2003 at the Medical Examiner's Office, that the three cases cited in the draft report are part of the backlog, and that this has hampered CFSA's ability to complete fatality review reports. However, CFSA does have autopsy results in all cases where the autopsy has been completed, and we continue to receives reports and updates regularly.[3]

4) After scrutinizing all maltreatment reports, screen all child care providers to assure that they are adhering to child care standards and take action to suspend licensure of those facilities involved in repetitive child fatality or neglect care.

As you know, CFSA does not license child care providers providing day care services and thus cannot suspend licenses. However, because child care is an area where children are at risk of abuse and neglect, and because CFSA can investigate reports of child maltreatment in these settings, we have taken a number of steps to improve child safety in these settings. These include:

- Providing mandated reporter training to child care providers and educating them about child abuse and neglect.
- Investigating incidents of alleged maltreatment by child care providers.
- Upon request of a child care provider, reviewing applicants for employment in child care settings to determine if their names appear on the Child Protection Registry.

5) Ensure that investigations of maltreatment incidents that are accepted by the Hotline be completed within 30 days after the initial contact with the alleged maltreated child.

CFSA's Court ordered Implementation Plan required that all investigations must be completed within 30 days. We have undertaken a number of initiatives in an effort to reach this goal, but have yet to fully realize it. Our efforts included:

- Hiring a new Intake and Investigations Administrator with over 25 years of child welfare experience.
- Hiring temporary staff to work on the backlog, transferring managers from other parts of the Agency to support the Intake management team, transferring cases from Intake to ongoing units, and supporting supervisors in Intake by identifying others in the Agency to assist in reading investigation reports.
- Creating a unit of experienced investigators, drawn from current units, who are focusing completely on the backlog;
- Implementing a referral closure incentive initiative;

[3] The only exception is where a child dies in another jurisdiction, where we sometimes have more difficulty in obtaining autopsy results.

CFSA'S RESPONSE TO DRAFT REPORT

- Equalizing assignment of new investigations through a rotation process;
- Creating a pool of social services assistants who are available to all staff and managed by a single support staff supervisor;
- Improving the case transfer process through implementing new protocols;
- Conducting a workload study to assess the proper staffing in Investigations; and
- Developing action plans for investigators needing to improve performance.

In March of 2004, we had a backlog of 668 cases where the investigation was open for more than 30 days. The investigations in all of those 668 cases have been completed, but unfortunately, as of February 10, 2005, we have a new backlog of 271 cases. However, our percentage of cases completed within 30 days has show improvement and the percent of cases open for 30 days or less increased as well, which shows continued progress in reaching the timeliness requirement.

6) Ensure that investigations of alleged maltreatment of children in CFSA's care who are located in another jurisdiction and are referred to that jurisdiction for investigation are actively monitored and obtain results and recommendations for action purposes.

Ensuring another jurisdiction completes an investigation and reports to us the results have been an issue for us and our success has depended largely on the jurisdiction involved. Under the leadership of our new Intake and Investigations Administrator, Heather Stowe, we are formalizing the process with other jurisdictions. In the meantime, we have a series of procedures in place, which allow us to track allegations of abuse or neglect taking place in other jurisdictions. These include:

- Obtaining regular reports from other jurisdictions in accordance with the Interstate Compact on the Placement of Children;
- Monitoring agencies in Maryland and Virginia where children are placed; and
- Enforcing the requirement that Unusual Incident Reports be submitted to the OLM when an incident takes place, whether in the District or another jurisdiction.

We would also like to take the opportunity in this letter to update you on our progress with regard to our handling of the reporting and investigation of abscondence, which you helped us identify as an issue needing attention. We have implemented the following changes to our prior policy:

- Clarified the definition of an absconding or missing child to be "... when the child is absent from the residence of a parent, caregiver, or facility without the knowledge or consent of the person(s) responsible for the child's welfare."
- Outlined specific protocols for reporting incidents of absconding children. The protocols assign clear obligations for social workers and our abscondence unit, and clearly outline when a neglect investigation must be undertaken. (See attached protocol.)
- Added a clerical position to the abscondence unit to assist with administrative finctions.
- Modified the FACES information and referral screen to (a) record that the hotline received a report that the child absconded, and (b) record that the child had returned. This enhanced feature provides the ability to see in FACES and report the name of the child, the date of the abscondence report and the date that the child is returned home.
- Trained all CFSA staff and the providers on the new protocols.
- Developed formats for new management reports which will allow a more accurate reporting of incidents of abscondence. The reports should be available by early April.

CFSA'S RESPONSE TO DRAFT REPORT

Conclusion

Thank you for the opportunity to comment on the draft report. I have attached some technical comments as well. If you have further questions, or seek additional clarification, please do not hesitate to contact me or my Chief of Staff, [redacted] (442-[redacted]).

Sincerely,

Brenda Donald Walker
Director, CFSA

Cc: Robert C. Bobb, City Administrator
Neil O. Albert, Deputy Mayor for Children, Youth Families and Elders

Attachments

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CFSA'S RESPONSE TO DRAFT REPORT

Specific recommended edits in audit document:

Along with incorporation what we reported above, there are also a series of specific edits we recommend. Many are recommended for clarity. The history of the District's child protection is quite complicated, and while you have captured it well, we think that the following edits will make it clear.

Page 1, ¶ 1 should read:

"In 1991, the District and the American Civil Liberties Union reached and agreement to improve the performance of the District's child protective function. Under the LaShawn A. v. Williams, Modified Final Order established by the court in 1993, the District was directed to comply with many requirements. In 1995, lacking sufficient evidence of improvement, the District was ordered to relinquish its authority over the child protective function, and it was placed in receivership. The district Court issued a consent order in 2000, establishing a process by which the receivership could be terminated."

Page 1, ¶ 2: the second sentence should read:

"In June 2001, the court terminated the receivership; the District established CFSA stand-alone, cabinet-level agency; and CFSA began a probationary period which lasted until January 2003.

Page 1, ¶ 3

CFSA has a fifth goal, thus insert:

"and (5) achieve permanence for children through reunification, kinship care, guardianship or adoption."

Page 1, ¶5
"Family Services" is called "In Home and Reunification Services"

Page 2, ¶3
We do not have a stand alone "Community Services Program". We have contracts with Collaborative Agencies, which serve the basic functions described in the report.

Page 8, first full ¶

In the first sentence, it is important to note that the CES reported an "*alleged* unwanted advance"

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CFSA'S RESPONSE TO DRAFT REPORT

Unusual Incident System

Incident Report for Council 9/1/04-9/30/04

Category:	Number of Incidents	Type of Home			
		Group Homes	ILP	Foster	Unknown
Absconsdence:	146	103	39	4	0
Abuse:	0	0	0	0	0
Alcohol:	1	0	0	1	0
Arrest of Child:	6	3	0	3	0
Assault without Injury:	11	7	0	4	0
Contraband:	6	4	2	0	0
Curfew Violation:	14	12	2	0	0
Destruction of Property:	10	7	1	2	0
Drugs:	5	4	0	1	0
Fatality:	0	0	0	0	0
Fire Hazard:	0	0	0	0	0
Medical:	12	7	1	4	0
Neglect:	3	3	0	0	0
Other:	22	15	4	3	0
Personal Injury:	2	2	0	0	0
Physical Assault:	13	11	2	0	0
Resident Ill:	0	0	0	0	0
School Related Incident:	22	22	0	0	0
Sexual Assault:	2	0	0	2	0
Sexualized Behavior:	1	1	0	0	0
Suicidal:	1	1	0	0	0
Theft:	4	3	0	1	0
Verbal Threat(Resident):	10	9	1	0	0
Verbal Threat(staff):	12	8	1	3	0
Violent Behavior:	6	2	0	4	0
Total :	276	197	54	25	0

*Adding up the # of incidents by category will not necessarily yield the total # of incidents because each incident may include multiple categories

Friday, February 11, 2005

Page 1 of 1